



SHINGLE SPRINGS HEALTH AND WELLNESS
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date and sign:

1. I, (Name of Patient): _____ DOB: _____, Telephone: () _____ hereby authorize the disclosure of information from my record.

2. The information is to be DISCLOSED BY: Name of Person/Organization/Facility: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone: () _____ Fax: () _____

And is to be PROVIDED TO: Name of Facility: Shingle Springs Health and Wellness Center Address: 5168 Honpie Road City: Placerville State: CA Zip: 95667 Telephone: (530) 387-4975 Fax: (530) 672-1507

3. The purpose of this disclosure is: _____

4. The information to be disclosed from my health record: (check appropriate box(es)): _____ Entire record _____ Only information related to event/illness (specify) _____ Only the period of events from: _____ to: _____ Other (specify): _____ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-Patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box (es) below.

_____ Alcohol/Drug Abuse Treatment/Referral _____ HIV/AIDS- related treatment _____ Sexually Transmitted Disease _____ Mental Health (other than psychotherapy notes)

5. I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, or if this authorization was obtained as a condition of providing insurance coverage, other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date. Expiration Date: _____

I understand that SSTHP will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may not longer be protected by the Health Insurance portability and Accountability Act (HIPAA) (45CFR Par164), and the privacy Act of 1975 (5usc 552a).

Signature of Patient or Authorized Representative Relationship to patient Date

Notes:

Office use only

Incomplete: _____

Complete: _____

Faxed: _____

Received: _____